



Molecular Genetics Requisition

Molecular Genetics Laboratory
4001 Leslie Street 3SE-186, Toronto, ON M2K1E1
Phone: (416) 756-6791 Fax: (416) 756-6197
www.nygh.on.ca/genetics/labs

Patient information/Place Label Here

Patient Name: _____
(Last) (First)

D.O.B.: _____ Sex: M / F
yyyy / mm / dd

Health Card#: _____

Address: _____

The DNA extracted from the patient's specimen (blood or tissues) will be destroyed one year after the test is reported. Some residual specimens may be used anonymously in the lab for test development or quality assurance purposes, unless waived by the patient.
I wish to waive the usage of my specimen by the lab. Patient/designate signature _____, Date _____

Specimen Collection Centre: _____ Collection Date (yyyy/mm/dd): _____
(Blood may be drawn at a community blood collection centre)

Specimen Requirements

| | | |
|---|--|---|
| <input type="checkbox"/> Blood 7 mL EDTA (lavender) 3 mL EDTA infant | Prenatal specimen: <input type="checkbox"/> Amniotic fluid 10 mL <input type="checkbox"/> Cultured amniocytes 2 x T25 flasks <input type="checkbox"/> CVS 10-20 mg cleaned villi on ice | <input type="checkbox"/> FFPE curls 5 µm x 10 <input type="checkbox"/> FFPE slides 5 µm x 4 plus one H&E staining slide <input type="checkbox"/> Tissue _____ |
| <input type="checkbox"/> DNA 1 - 5 µg tissue source: _____ | | |

Tests

- | | |
|---|--|
| <input type="checkbox"/> Familial Thrombophilia • Factor II c.*97G>A and Factor V Leiden | <input type="checkbox"/> Molar Pregnancy |
| <input type="checkbox"/> Hemochromatosis • C282Y and H63D | <input type="checkbox"/> Maternal Cell Contamination |
| <input type="checkbox"/> Fragile X syndrome (FXS) | <input type="checkbox"/> Specimen Misidentification |
| <input type="checkbox"/> Fragile X-associated premature ovarian insufficiency (FXPOI) | <input type="checkbox"/> Uniparental disomy 14 (UPD14) |
| | <input type="checkbox"/> Uniparental disomy 15 (UPD15) |

Infertility: Y Chromosome Microdeletion (Non-OHIP covered test, a laboratory test fee is applicable)

Neurological Disorders:

- | | |
|--|--|
| <input type="checkbox"/> C9orf72-related disorders | <input type="checkbox"/> Spinocerebellar ataxia (SCA) panel OR |
| <input type="checkbox"/> Dentatorubro-pallidoluysian atrophy (DRPLA) | <input type="checkbox"/> SCA1 |
| <input type="checkbox"/> Fragile X-associated tremor/ataxia syndrome (FXTAS) | <input type="checkbox"/> SCA2 |
| <input type="checkbox"/> Friedreich ataxia (FRDA) | <input type="checkbox"/> SCA3 (Machado-Joseph disease) |
| <input type="checkbox"/> Huntington disease (HD) | <input type="checkbox"/> SCA6 |
| <input type="checkbox"/> Oculopharyngeal muscular dystrophy (OPMD) | <input type="checkbox"/> SCA7 |
| <input type="checkbox"/> Spinal bulbar muscular atrophy (SBMA) | <input type="checkbox"/> SCA8 |
| | <input type="checkbox"/> SCA17 |

Information Requested/Reason for Referral

- | | |
|--|---|
| <input type="checkbox"/> Diagnostic testing (patient has symptoms of disorder) | <input type="checkbox"/> Prenatal diagnosis |
| <input type="checkbox"/> Predictive testing (referral to genetics clinic is recommended) | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Carrier status (family history of this disorder) | |

Patient/Family Information

Pregnancy information

Have samples from this patient or family been sent to this DNA lab before? No Yes

Gestation age: _____ weeks

If Yes, Name: _____ Relationship to your patient: _____

Referring Physician:

Copy report to:

Name _____ Tel (____) _____ Fax (____) _____

Name: _____

Address _____ City _____ Province/Postal Code _____

Address: _____

Signature _____

Tel (____) _____ Fax (____) _____

NYGH LAB USE ONLY

Date received: _____

Ped #: _____ Lab Label: _____

Sample Requirements

Requisition

Complete this Requisition including:

- Patient information: patient's name, date of birth, sex and Ontario Health Card number.
- Specimen information: specimen type, sample collection centre and date of collection.
- Test(s) requested.
- Information Requested/Reason for Referral.
- Patient/Family and Pregnancy information.
- Please print referring physician name, address, phone and fax numbers. Signature is required.
- Any missing information may delay the test.

Sample Requirements

NOTE: Referred in blood samples will NOT be drawn at NYGH

- Minimum quantity of sample required is indicated on the requisition. Specimens received in the incorrect anti-coagulant will be rejected.
- Label specimen containers with at minimum the individual's first and last names and date of birth.
- If the patient has had a blood transfusion, a minimum of **3 weeks** between the time of transfusion and blood collection for molecular testing is required.
- Blood specimens from patients who have had an allogenic transplant (bone marrow or stem cell) will NOT be accepted.
- Tissue samples must be collected in phosphate buffered saline (PBS).
- FFPE tissue samples (Do not send blocks):
 - ✓ FFPE curls: Ten 5 µm tissue curls sequentially cut from FFPE blocks
 - ✓ FFPE slides for molar pregnancy testing: Four slides sequentially cut of 5 µm thickness plus one H&E slide with **villous (F)** and **decidual (M)** areas clearly marked.

Please note:

Slides will not be returned.

When cutting slices of paraffin-embedded tissue, please ensure that the microtome is cleaned well before use and re-cleaned between cutting each block. This is to prevent contamination of samples with DNA from other samples.

Shipping Instructions

- Ship specimens at **room temperature** by overnight courier such that the specimen arrives in the Laboratory Monday to Friday
- Samples should be shipped as soon as possible after collection
- Specimens held for a few days prior to shipping should be maintained at 4°C
- When shipping specimens, follow the regulations of the Transportation of Dangerous Goods Act (1992, C.34)